UTAH DEPARTMENT OF HEALTH
Children with Special Health Care Needs

# Financial Form (PFR)

**A**

| Patient Name: | DOB: |
|---|---|

| Primary Insurance Name: | Primary Insurance ID #: |
|---|---|
| Primary Policy Holder's Name: | Primary Insurance Group #: |

| Secondary Insurance Name: | Secondary Insurance ID #: |
|---|---|
| Secondary Policy Holder's Name: | Secondary Insurance Group #: |

**Is patient receiving SSI (Supplemental Security Income)?** ☐ Yes ☐ No

**Is patient receiving Medicaid, CHIP, or FEP/TANF?** ☐ Yes ☐ No **If "Yes", skip to Section C below.**

**B**

**Financial Assistance Available**: You may be eligible for financial assistance for services provided by Children with Special Health Care Needs. To help us determine your eligibility for assistance, please complete the following information, **and provide your last three consecutive pay check stubs, or most recent IRS tax return (front page is sufficient).**

☐ **I decline to fill out the section below. I understand that by withholding this information, I will not be eligible for financial assistance for services provided and may be liable for all or a portion of the bill.**

| | |
|---|---|
| Number of Children (If pregnant, include the unborn child) | _____ |
| Number of Adults (Including yourself, spouse and any eligible adults) | _____ |

→ **Total Family Size**

**MONTHLY Gross Income for Family**

| | |
|---|---|
| MONTHLY Gross salary (primary wage earner): Before Taxes, Social Security, Insurance Premiums, Union Dues | $ _____ |
| MONTHLY Gross salary (other wage earner(s)): | $ _____ |
| Other MONTHLY income: Includes pensions, compensations, income from rentals, interest, dividends, alimony or child support, public assistance grants, etc. ***SSI income is NOT included as income*** | $ _____ |
| **Total Monthly Gross Income*** | $ _____ |

**MONTHLY Expenses for Family** (Out of pocket)

| | |
|---|---|
| Medical/Dental Expenses | $ _____ |
| Medical/Dental Premiums | $ _____ |
| Child Support or Alimony | $ _____ |
| Child Day Care Costs | $ _____ |
| **Total Monthly Expenses**** | $ _____ |

*Shaded area for agency use only*

| | | | |
|---|---|---|---|
| Total Monthly Gross Income* $ _____<br>Total Monthly Expenses** $ _____<br>**Total Net Income** $ _____ | **P**ersonal **F**inancial **R**esponsibility (PFR) | 0% 20% 40% 60% 100% | Y N |

**C**

**I understand that my Financial Responsibility will be calculated based on the information I provided above. I understand that I may be liable for all or a portion of the bill and that interest may be charged on accounts unpaid 60 days after billing date.**

_____ _____
Print Name of Patient or Legal Representative — Date

_____
Signature of Patient or Legal Representative

☐ Parent of minor child ☐ Self (18 or older)
☐ Medical Power of Attorney ☐ Legal Representative
☐ Other, explain and attach documentation
_____

_____ _____
Name of CSHCN Representative (Please Print) — Date



Note: A new form is required annually or any time there is a change in family size or income.

********** Required Information **********

# CSHCN Financial Form Worksheet References

## Allowable Medical Expenses

Qualifying expenses must be directly related to the health or medical condition of a family member. Expenses must be out of pocket for the previous 12 months and for which you will not be reimbursed.

- Capital expenses for equipment or improvements to your home needed for medical care
- Cost and care of guide animals aiding the blind, deaf, and disabled
- Cost of lead based paint removal
- Expenses of an organ transplant
- Hospital services fees (lab work, therapy, etc.)
- Birth control pills, legal abortion, legal operations
- Meals and lodging provided by a hospital during medical treatment
- Medical and hospital insurance premiums
- Medical services fees (from doctors, dentists, surgeons, specialists and other medical practitioners)
- Oxygen equipment and oxygen
- Prescriptions, medicines, and insulin
- Tutoring recommended by a doctor
- Psychiatric care at a specialty equipped medical center (includes meals and lodging)
- Special items (hearing aids, wheelchairs, etc.)
- Special school, tuition, meals and lodging
- Transportation for medical care
- Treatment at a drug or alcohol center
- Wages for nursing services
- Diaper costs related to medical problem

## What cannot be included as expenses:

- Diaper services
- Health club dues
- Household help
- Stop smoking program
- Weight loss program
- Life insurance or income protection policies
- Maternity clothes
- Medicine bought without a prescription
- Nursing care for a healthy baby
- Surgery for purely cosmetic reasons



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